

QUALITY INDICATORS VERSUS QUALITY MEASURES

Quality indicators are not direct measures of quality; they are pointers that indicate potential problem areas that need further review and investigation. Quality indicators are the starting point for a process of evaluating the quality of care through careful investigation. A true measure of quality identifies an aspect of care where there definitely is a problem and describes the extent of the problem. Quality measures are their own end points; no further investigation is needed in order to make judgments about the quality of care. Consumers, policy-makers and many others who are interested in the quality of care provided by a facility are not able to conduct clinical investigations. They need information that clearly relates to actual problems. They need true quality measures which, unlike quality indicators, become the sole judge of quality.

The Center for Health Systems Research and Analysis (CHSRA) QIs are quality indicators. Therefore a high percentile ranking on a particular QI (e.g., 92nd percentile on QI 2 - Prevalence of Falls) on your quarterly QI report does not necessarily mean that there is a problem with the quality of care in your facility. It simply means that there is a flag that draws your attention to a potential problem that you may want to investigate. By the same token, having an average or low score on a particular QI (e.g., 21st percentile on QI 10 - Prevalence of Indwelling Catheters) does not mean that there is not a quality problem; there may be problems with quality of care that are not captured by the QIs. Careful Investigation can help you decide if a high QI percentile rank is really identifying a quality problem. Other sources of information (e.g., progress notes) may be helpful with the issue of identifying quality problems that are not covered by the QIs.

The CHSRA QIs can be used to identify concerns which will need further investigation; but on their own, they should not be used to make final judgments about the quality of care. The final decision of whether or not there is a quality problem requires careful and skilled investigation by clinical experts. This is an important consideration for how you, or others, use the information in the QI reports. For example, in the future State surveyors will be able to access QI reports. They will be able to use the reports to focus their onsite survey to potential problem areas, however they will also need to carefully investigate the potential problem areas in order to determine whether deficiencies should be issued.

Likewise, you should be careful to not use the information in your QI reports to draw specific comparisons to other facilities or portray the overall quality of your facility as compared to other facilities. The QI information in your reports is extremely useful in helping you identify areas or systems in your facility that may be improved, but the QI reports should not be used as the single judge of the quality of care your facility delivers. A final determination of quality requires detailed clinical review and investigation.

THE CHARACTERISTICS OF THE QUALITY INDICATORS (QIs)

The quality indicators (QIs) are markers that indicate either the presence or absence of potentially poor care practices or outcomes. QIs represent the first known systematic attempt to longitudinally record the clinical and psycho-social profile of NF residents in a standardized, relatively inexpensive, and regular manner by requiring the expertise of only in-house staff. The QIs can be best described by addressing their characteristics along the following dimensions: (1) resident versus facility level, (2) prevalence versus incidence, and (3) process versus outcome.

RESIDENT/FACILITY LEVEL QIs

At the resident level, QIs are defined either as the presence or absence of a condition. The resident level QIs can be aggregated across all residents in a facility to define facility level quality indicators. Facility level QIs can be used to compare any given facility with others or with nursing home population norms at the state or multistate level. An example of a resident level QI is the prevalence of stage 1-4 pressure ulcers defined as 1 if the resident has pressure ulcers (stage 1-4) on the most recent assessment and 0 otherwise. The corresponding facility level indicator is the proportion of residents of a facility that have one or more pressure ulcers, that is, the number of residents with pressure ulcers (stage 1-4) on the most recent assessment divided by the total number of residents in that facility.

PREVALENCE/INCIDENCE

QIs that are defined as the presence or absence of a condition at a single point in time is called a "prevalence QI", whereas a QI capturing the development of a condition over time (on two consecutive assessments for example) is called an "incidence QI". It should be noted that while prevalence in QIs relate to a single point in time for each resident, at the facility level they represent the prevalence of conditions over a three-month period, since the most recent assessment across the population of residents can occur over a quarter.

PROCESS VS. OUTCOME

QIs cover both process and outcome measures of quality. Process indicators represent the content, actions and procedures invoked by the provider in response to the assessed condition of the resident. Process quality includes those activities that go on within and between health professionals and residents. Outcome measures represent the results of the applied processes. In the case of long term care it maybe most relevant to think in terms of a change in or continuation of health status. Outcome quality then should be represented by both point prevalence and incidence measures.

The distinction between a process and outcome QI is not always straightforward. In some cases the QI is a combination of an outcome and a process, in that it reflects both of them. An example is the prevalence of symptoms of depression (outcome) with no treatment (process) indicated. In other cases the QI can be considered either an outcome or a process measure, depending on the particular situation and one's philosophical orientation. An example is the QI "prevalence of little or no activity." This QI can be thought of as reflecting the status (outcome) of the resident (i.e., the resident is not able to or chooses not to engage in activities), or as a process of care (i.e., the facility staff elects not to provide or arrange for the activities). It may require subsequent investigation to determine whether, for a particular resident, the QI is more reflective a process or an outcome of care.

The QIs were designed to cover both process and outcome of care and to include both prevalence and incidence types of measure.

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